

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-049159

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 314 Primary Registration District No. 4439 Registrar's No. 72

FILED JAN 13 1964

VS 300  
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK  
OR  
TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY St. Clair		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Clair	
b. CITY (If outside corporate limits, give TOWNSHIP only) Osceola		c. CITY OR TOWN Kansas City	
Length of stay in 1b 14 days		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Osceola Med; Hosp;		d. STREET ADDRESS (If outside, give location) 5010 N-Winchester	
Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Georg -- Giefling			4. DATE OF DEATH Month Day Year December 29, 1963
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1-10-78
9. AGE (last birthday) 85	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cabinet Maker		11. BIRTHPLACE (City and state or country) Hungary
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cabinet Maker		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME John Giefling		13b. MOTHER'S MAIDEN NAME Barbara Nuschy	
14. NAME OF HUSBAND OR WIFE Mrs. George Giefling, K.C.Mo			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) No		16. SOCIAL SECURITY NO. 068	
17. INFORMANT Mrs. George Giefling, K.C.Mo		Address	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: a. IMMEDIATE CAUSE (a) Cerebral hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 14 days	
b. DUE TO (b) c. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE		
21. attended the deceased from 15 Dec 63 to 29 Dec 63 and last saw him alive on 29 Dec 63 Death occurred 12:30 AM on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Osceola MO		22b. ADDRESS Osceola MO	
22c. DATE SIGNED 20 Jan 64			
23. BURIAL, CREMATION, or other final disposition Burial	23b. DATE 1-2-64	23c. NAME OF CEMETERY OR CREMATORY Mt. Carmel	23d. LOCATION (City, town, or county) K.C. MO
24. FUNERAL DIRECTOR 2 Home Osceola MO	ADDRESS	25. DATE RECD. BY LOCAL REG. 1-10-64	26. REGISTRAR'S SIGNATURE Ruth Sauer

(Licensed Embalmer's Statement on Reverse Side)

